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Supreme Court of the United States

OCTOBER TERM, 1999

DON STENBERG, Attorney General of the State of Nebraska, *et al.*,

Petitioners,

—v.—

LEROY CARHART, M.D.,

Respondent.

ON WRIT OF *CERTIORARI* TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF *AMICI CURIAE* THE AMERICAN CIVIL LIBERTIES UNION; EMW WOMEN'S SURGICAL CENTER, P.S.C.; SAMUEL G. EUBANKS, M.D.; MARK I. EVANS, M.D.; MARILYNN CONNERS FREDERIKSEN, M.D.; NORMAN A. GINSBERG, M.D.; CASSING HAMMOND, M.D.; HERBERT HOLMES, M.D.; THE HOPE CLINIC; TIMOTHY R.B. JOHNSON, M.D.; ERNEST W. MARSHALL, M.D.; RHODE ISLAND MEDICAL SOCIETY; PABLO RODRIGUEZ, M.D.; DUANE ST. CLAIR, M.D.; LAUREN STREICHER, M.D.; GERSON WEISS, M.D.; GLENN H. WEYHRICH, M.D.; AND DAVID ZBARAZ, M.D., IN SUPPORT OF RESPONDENT

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INTERESTS OF *AMICI*[1]

Amici submit this brief in support of Respondents and in support of affirmance. *Amici* Drs. Samuel G. Eubanks, Mark I. Evans, Marilynn Conners Frederiksen, Norman A. Ginsberg, Cassing Hammond, Herbert Holmes, Timothy R.B. Johnson, Ernest W. Marshall, Pablo Rodriguez, Duane St. Clair, Lauren Streicher, Gerson Weiss, Glenn H. Weyhrich, David Zbaraz, EMW Women's Surgical Center, P.S.C., and The Hope Clinic are physicians and clinics that provide medical care, including abortions, to women in Idaho, Illinois, Kentucky, Michigan, New Jersey, and Rhode Island. *Amicus* Rhode Island Medical Society is a voluntary association of approximately 1500 physicians and medical students in Rhode Island -- some of whom provide abortions -- that advocates for quality medical care in Rhode Island. These *amici* are plaintiffs in cases that will be directly affected by the outcome in this case. The cases in which *amici* are parties are pending in this Court, in the United States Courts of Appeals for the First, Third, and Sixth Circuits, and in the United States District Courts for the District of Idaho[2] and the Eastern District of Michigan.

Amicus American Civil Liberties Union is a nationwide nonpartisan organization of nearly 300,000 members dedicated

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[1] Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3. Pursuant to Rule 37.6, counsel for *amici* state that no counsel for a party authored this brief in whole or in part, and no person, other than *amici*, their members, or their counsel, made a monetary contribution to the preparation or submission of this brief.

[2] *Amici* Drs. St. Clair and Weyhrich were plaintiffs in a challenge to Idaho's "partial-birth abortion" ban, in which the Idaho Attorney General consented to a permanent injunction. As an *amicus* before this Court, however, the Idaho Attorney General urges reversal of the decision below, suggesting that, should this Court reverse, the Idaho Attorney General may seek to vacate the injunction and enforce the Idaho ban.

to protecting the fundamental liberties and basic civil rights guaranteed by the United States Constitution. The ACLU has long been committed to protecting the constitutional right to reproductive choice, and has appeared in this Court in defense of that right in cases from *Doe v. Bolton*, 410 U.S. 179 (1973), to *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). The ACLU represents the other *amici* in the pending cases referenced above.

SUMMARY OF ARGUMENT

Under this Court's longstanding precedent, a law that prohibits the performance of safe and common abortion procedures cannot stand. *Planned Parenthood v. Danforth*, 428 U.S. 52, 75-79 (1976). Yet, as the Eighth Circuit and the district court in this case properly held, the Nebraska "partial-birth abortion" ban, Neb. Rev. Stat. §§ 28-326(9), 28-328(1)-(4) (1998) (the Act), at a minimum, reaches the dilation and evacuation (D&E) procedure, by which the overwhelming majority of second-trimester abortions in Nebraska and the nation are performed. That holding has been echoed by courts across the country invalidating similar or identical bans.

In the face of these holdings, the state insists that the Act proscribes only a variant of D&E known as dilation and extraction (D&X). Presumably recognizing that the language of the Act encompasses considerably more than D&X, the state offers revisions for this Court's consideration. Yet even if the Act were readily susceptible to the proposed constructions (which it is not), a ban rewritten to the state's specifications would still impermissibly prohibit D&E. A statute that criminalizes the most common method of second-trimester abortion unquestionably imposes an unconstitutional, undue burden on the right to reproductive choice.

Beyond assuring access to the most common abortion procedures, however, the Constitution protects a woman's right

to end her pregnancy by the method that is best for her health. A ban on any abortion procedure within the standard of care, including a ban on D&X alone, would deprive some women in some circumstances of access to the procedure safest for them, forcing them to submit instead to riskier methods. The district court's findings of fact in this case, amply supported by the evidence, establish that a ban on D&X would expose women to appreciably greater health risks -- including, among others, risks of cervical laceration, severe infection, and uterine perforation followed by massive hemorrhage -- than they would otherwise face. Even for women whose health conditions give them especially strong reasons to avoid these and other risks, the ban is absolute: It contains no exception to protect a woman's health and only an insufficient exception to save her life.

The Constitution does not permit the government to subordinate a woman's interest in protecting her health, even to the state's interest in preserving *viable* fetal life. *Casey*, 505 U.S. at 846, 879; *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768-71 (1986), *overruled in part on other grounds by Casey*, 505 U.S. at 882; *Colautti v. Franklin*, 439 U.S. 379, 397-401 (1979). *A fortiori* the Constitution cannot tolerate a statute, like Nebraska's, that subjects women to riskier abortion procedures before viability when the fetus has no present chance of survival. Moreover, the Constitution mandates an exception to permit otherwise banned procedures when a pregnant woman's life or health is at stake. *Casey*, 505 U.S. at 846, 879-80. Because the Act prevents a woman from pursuing her overriding interest in preserving her health, it cannot survive the exacting scrutiny demanded by this Court's abortion jurisprudence.

Indeed, here, the state lacks even a legitimate interest in the ban it is defending. The Act advances neither of the two interests identified in *Casey* -- in protecting maternal health or fetal life. 505 U.S. at 871. The Act threatens, rather than

protects, the health of pregnant women. And if the Act is intended to ban only one procedure (as the state insists), it is plainly *not* meant to protect potential life, but rather to steer women from one abortion method to another. Nor is there evidence in any case filed anywhere in the nation establishing that the D&X procedure is more painful or cruel to the fetus than its alternatives or even that previable fetuses consciously experience pain. The remaining interests asserted by the state amount to expressions of repugnance, a limitless state interest that cannot be deemed legitimate. If repugnance alone were sufficient to support bans on various abortion procedures, a woman's right to obtain a safe and legal abortion would soon disappear. Yet this Court has held that the state may not "resolve the[] philosophic questions [surrounding abortion] in such a definitive way that a woman lacks all choice in the matter." *Casey*, 505 U.S. at 850.

ARGUMENT

I. THE ACT IMPERMISSIBLY PROHIBITS SAFE AND COMMON ABORTION PROCEDURES.

Along with the vast majority of courts to consider "partial-birth abortion" bans, the Eighth Circuit and the district court in this case properly held that such bans impose an undue burden on the right to reproductive choice because they reach safe and common procedures, and particularly D&Es. These holdings are based on amply supported findings that these common abortion methods contain all the elements of the conduct criminalized under the bans. Implicitly acknowledging that the words of the legislation cover too much, the state proffers interpretive glosses. Yet even if the new language urged by the state could be read into the ban, it would still criminalize D&E in general -- and not only the D&X variant of D&E.

A ban that reaches safe and common abortion procedures impermissibly "plac[es] a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Casey*, 505 U.S. at 878. In *Danforth*, for example, this Court held unconstitutional a ban on saline inductions, which then accounted for the vast majority of second-trimester abortions. 428 U.S. at 75-79. Relying in part on *Danforth*, this Court later struck down a requirement that all second-trimester abortions take place in a hospital. *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 431-39 (1983), *overruled in part on other grounds by Casey*, 505 U.S. at 882-85. Recognizing that D&Es -- which had begun to supplant saline inductions -- could be safely performed outside hospitals, this Court held that the ban on "the performance of D&E abortions in an appropriate nonhospital setting . . . imposed a heavy burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *Id.* at 438.

Based on this and other precedent, courts across the country have invalidated "partial-birth abortion" bans because they prohibit previability procedures including D&E, by which over 90% of second-trimester abortions in this country are now performed. J.A. at 533 (Centers for Disease Control data).[3] In

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[3] *See Planned Parenthood v. Miller*, 195 F.3d 386, 388-89 (8th Cir. 1999), *aff'g* 30 F. Supp. 2d 1157, 1165-67 (S.D. Iowa 1998); *Carhart v. Stenberg*, 192 F.3d 1142, 1149-51 (8th Cir. 1999), *aff'g* 11 F. Supp. 2d 1099, 1127-31 (D. Neb. 1998); *Little Rock Family Planning Servs. v. Jegley*, 192 F.3d 794, 797-98 (8th Cir. 1999), *aff'g* No. LR-C-97-581, slip op. at 46-51 (E.D. Ark. Nov. 13, 1998); *Weyhrich v. Lance*, Civ. No. 98-0117-S-BLW, slip op. at 6-9, 10 (D. Idaho Oct. 12, 1999); *Rhode Island Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 309-10, 313-14 (D.R.I. 1999), *appeal stayed*, No. 99-2095 (1st Cir. Nov. 22, 1999); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604, 614 (E.D. La. 1999), *appeal argued*, No. 99-30324 (5th Cir. March 2, 2000); *Planned Parenthoood v. Verniero*, 41 F. Supp. 2d 478, 493, 499-500 (D.N.J. 1998), *appeal argued*, No. 99-5042 (3d Cir. Nov. 19, 1999); *A Choice for* (continued...)

a D&E, as described by the district court below in findings properly affirmed by the Eighth Circuit, the physician first gradually dilates the cervix, over the course of hours or even days. At the start of surgery, the physician ruptures the membranes that enclose the amniotic sac. Inserting forceps through the cervix and into the uterus, the physician then grasps "a portion of the fetus, pulls it through the cervical os [the dilated but still narrow opening of the cervix], and dismembers various fetal parts by traction created between the instrument and the cervical os." *Carhart*, 11 F. Supp. 2d at 1104; 192 F.3d at 1147, 1150. Thus, the dismemberment of the fetus typically occurs "after a part of the fetus has been pulled through the cervix, into the vagina." *Carhart*, 192 F.3d at 1147. The physician completes the removal of the fetus after causing its death by repeatedly grasping fetal parts, delivering them into the vagina, and dismembering them at the cervical os. *See Carhart*, 11 F. Supp. 2d at 1103-05; 192 F.3d at 1146-48.

In "an effort to minimize perforation of the uterus or cervix by instruments used during a D&E or from piercing caused by fetal parts," some physicians attempt to deliver the fetus in as intact a condition as possible. *Carhart*, 11 F. Supp. 2d at 1105. In one form of intact delivery during a D&E, the physician "brings all of the fetus, except for the head, out of the uterus into the vagina. Because the cervix is not dilated enough to allow the head to pass through, the physician . . . collaps[es] the skull[,] allowing removal of an [otherwise] intact fetus." *Carhart*, 192 F.3d at 1147-48. A D&E that proceeds in this way is here referred to as a D&X.

The state insists that its "partial-birth abortion" ban proscribes only the D&X procedure. Whatever meaning the state may ascribe to the non-medical term "partial-birth abortion," *see* Pet'rs' Br. at 7, 15, "[t]he issue here is *the Act's* definition," *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 305 (emphasis added), which is binding. As this Court has made clear, a statutory "definition which declares what a term 'means' . . . excludes any meaning that is not stated." *Colautti*, 439 U.S. at 392 n.10 (internal quotation omitted).

The Act bans any abortion in which the physician

> partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. . . . [T]he term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the [physician] knows will kill the unborn child and does kill the unborn child.

Neb. Rev. Stat. § 28-326(9). Several courts have correctly held that virtually identical language -- and particularly the imprecise phrase "substantial portion" -- impermissibly leaves physicians uncertain about what abortion procedures the statute prohibits

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[3](...continued)
Women v. Butterworth, 54 F. Supp. 2d 1148, 1155-56 (S.D. Fla. 1998); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024, 1034-35 (W.D. Ky. 1998), *appeal argued*, No. 99-6671 (6th Cir. Dec. 15, 1999); *Intermountain Planned Parenthood v. Montana*, No. BDV 97-477, slip op. at 4, 12-13 (Mont. Dist. Ct. June 29, 1998); *Planned Parenthood v. Alaska*, No. 3AN-97-6019 CIV, slip op. at 9-10, 15-17 (Alaska Super. Ct. Mar. 13, 1998), *appeal docketed*, No. S-08610 (Alaska Apr. 13, 1998); *Planned Parenthood v. Woods*, 982 F. Supp. 1369, 1377-78 (D. Ariz. 1997); *Evans v. Kelley*, 977 F. Supp. 1283, 1317-18 (E.D. Mich. 1997); *cf. Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 198-201 (6th Cir. 1997) (definition of banned procedure in D&X ban encompassed D&Es), *aff'g* 911 F. Supp. 1051, 1063-67 (S.D. Ohio 1995).

and is therefore unconstitutionally vague.[4] *Amici* agree. Whatever the precise scope of the bans, however, one thing is clear: The banned conduct includes D&Es.

This is evident from the elements of the crime of "partial-birth abortion." The state itself recognizes that the Act proscribes any procedure "involving the intentional '1) partial delivery of a living fetus vaginally, 2) killing the fetus and 3) completing the delivery.'" *Carhart*, 192 F.3d at 1150 (quoting 8th Cir. Br. of Nebraska at 66-67). As the Eighth Circuit correctly held, "the D&E procedure involves all three of those steps. The physician intentionally brings a substantial part of the fetus into the vagina, dismembers the fetus, leading to fetal demise, and completes the delivery." *Id.* As another court found, considering a ban nearly identical to Nebraska's,

> In a D&E abortion, ... part of the intact fetus may be in the vagina and part in the uterus or a disarticulated part of the fetus may be in the vagina while the remainder of the fetus is in the uterus. The fetus may still have a heartbeat. . . . In any of these situations, the next step taken by the physician, before completing the delivery, may kill the fetus. This would bring the D&E within the Act's definition of a "partial-birth abortion."

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[4] *E.g., Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 309, 310-12 ("'substantial portion' is vague and does not provide doctors with sufficient guidance to know what the Legislature has made illegal"); *Butterworth*, 54 F. Supp. 2d at 1157-58 (same as to "partially vaginally delivers"); *Miller*, 30 F. Supp. 2d at 1165 (same as to "partially vaginally delivers," "substantial portion," and "living fetus"); *Verniero*, 41 F. Supp. 2d at 491-94 (same as to "partially vaginally delivers," "living human fetus," and "substantial portion"); *Evans*, 977 F. Supp. at 1305-11 (same as to "partially vaginally delivers a living fetus").

Verniero, 41 F. Supp. 2d at 493. Accordingly, the district court in this case held that "[t]he words of the statute, fairly read, prohibit the D&E procedure" because "[d]octors routinely 'deliberately and intentionally' deliver 'vaginally' a 'substantial portion' of a living fetus in order to kill it when performing a D&E." *Carhart*, 11 F. Supp. 2d at 1128, 1129. This holding is echoed by courts striking similar or identical "partial-birth abortion" bans throughout the country.[5]

None of the judicial tampering with the legislation that the state -- or state defendants in other cases -- have urged would exclude D&E from the Act's prohibition. Even if the ban were rewritten to limit its application to partial deliveries of *intact* fetuses -- a revision numerous courts have declined to make,[6] and one the state urges only by implication -- such an interpretation would not exclude D&E. For, as discussed above, "when a fetus is dismembered [in a D&E] the dismemberment routinely involves an intentional and deliberate vaginal delivery of a 'substantial portion' of the *intact* fetus in order to

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[5] *See supra* note 3. Based on similar factual findings, several of these courts have also held that the bans would prohibit some first-trimester suction curettage abortions, in which the physician evacuates the uterus by means of suction, and some second-trimester induction abortions, in which the physician induces premature labor. *Miller*, 195 F.3d at 389 (suction curettage); *Jegley*, 192 F.3d at 798 (suction curettage); *Butterworth*, 54 F. Supp. 2d at 1155-56 (induction); *Verniero*, 41 F. Supp. 2d at 493 (suction curettage and induction); *Weyhrich*, Civ. No. 98-0117-S-BLW, slip op. at 6, 10 (suction curettage and induction); *Woods*, 982 F. Supp. at 1378 (induction); *cf. Causeway*, 43 F. Supp. 2d at 614; *Planned Parenthood v. Alaska*, No. 3AN-97-6019 CIV, slip op. at 17.

[6] *E.g.*, *Verniero*, 41 F. Supp. 2d at 491-94; *Miller*, 30 F. Supp. 2d at 1165-66; *Evans*, 977 F. Supp. at 1306-07.

accomplish dismemberment." *Carhart*, 11 F. Supp. 2d at 1121 (emphasis added); *see also Carhart*, 192 F.3d at 1147, 1150.[7]

Reading "intact" into the Act would not remove D&E from its sweep for the additional reason that dismemberment is not a necessary part of all D&Es. Contrary to the state's assertion, the "object" of a D&E is not "to dismember" the fetus, Pet'rs' Br. at 7, but rather, as in all abortions, to empty the uterus as safely as possible for the woman. *Verniero*, 41 F. Supp. 2d at 494. "For reasons of medical safety," physicians attempt to minimize repeated instrumentation inside the uterus by "bring[ing] as much of the fetus into the vagina as possible when performing a D&E." *Eubanks*, 28 F. Supp. 2d at 1035. Dr. Carhart, for example, "intends to remove the fetus intact for any abortion performed past 15 weeks' gestation," although he achieves intact delivery in only a small percentage of cases. *Carhart*, 11 F. Supp. 2d at 1106, 1108, 1121-22. A physician, like Dr. Carhart, who aims to increase the safety of D&E by delivering as much of the fetus as possible with each pass of the instrument, knows that the procedure may progress in a way that brings it within the scope of prohibited conduct, even as narrowly drawn as the state claims: The physician may deliver an intact fetus in breech position up to the head and then

[7] The state also fails to narrow the Act through its claim that "a distinguishing feature of the statute is its focus on the place where the killing act occurs." Pet'rs' Br. at 17. This argument hinges on the state's mistaken belief that the "killing act" of a D&X occurs in the vagina, whereas in a D&E the act that causes fetal demise occurs in utero. That characterization is both overly simplistic and wrong. As just described, when a D&E entails dismemberment, that "killing act" generally occurs when the physician's instruments are grasping a fetal part *outside* the uterus that is still attached to the rest of the fetus, which remains in utero. *See, e.g.*, *Carhart*, 192 F.3d at 1147. Conversely, in a D&X, "the puncture and suctioning [of the skull] occurs *inside* the uterus." *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 307 (emphasis added).

collapse the skull if it lodges within the uterus. *E.g.*, *Verniero*, 41 F. Supp. 2d at 484, 493.

In addition to illustrating the breadth of the Act, these facts reflect what the state goes to great lengths to obscure by rhetorically contrasting "D&X" with "the D&E dismemberment procedure," Pet'rs' Br. at 7, 11, 15-17: D&X is "a form of D&E" or "a variant" of it, *Carhart*, 11 F. Supp. 2d at 1105, 1121 (internal quotations and citations omitted). The two procedures are not as easily distinguished as the state would have the Court believe, and nothing in the Act targets one while excluding the other. *See Hope Clinic v. Ryan*, 195 F.3d 857, 879 (7th Cir. 1999) (en banc) (5-4 decision) (Posner, C.J., dissenting) ("[I]t is extremely difficult, indeed probably impossible, to distinguish a 'partial birth' abortion from the methods of abortion that are conceded to be privileged."); *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 297-98 ("D&X is merely a subset, a defined group of procedures that would have been called a D&E until doctors and medical groups carved it out.").

As is apparent from this discussion of how D&Es are actually performed, even if the Court were to accept Nebraska's latest and more elaborate articulation of the elements of the crime -- with its reference to partial delivery for the purpose of performing a "separate and distinct 'procedure'" that kills the fetus, Pet'rs' Br. at 17; *see also id.* at 14 -- the Act would still ban D&E in general, and not only D&X.[8] In a D&E involving

[8] Inserting words absent from the Act -- such as "separate and distinct" before the word "procedure," Pet'rs' Br. at 17 -- would be improper for several reasons. First, if, as here, a statute is not "'readily susceptible'" to a limiting construction, federal courts "will not rewrite a state law to conform it to constitutional requirements." *Virginia v. American Booksellers Ass'n*, 484 U.S. 383, 397 (1988); *see also Reno v. ACLU*, 521 U.S. 844, 884 (1997). Second, as described in the text accompanying this note, inserting these words would not in any event prevent application of the Act to D&E, which

(continued...)

dismemberment, "[t]he doctor grabs a substantial portion of the fetus and delivers it into the vagina. This is done with the intent of performing a second procedure -- the pulling and traction -- that the doctor knows will kill" the fetus. *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 309; *see also Carhart*, 192 F.3d at 1150 ("The physician intentionally brings a substantial part of the fetus into the vagina, dismembers the fetus, leading to fetal demise, and completes delivery."); *Eubanks*, 28 F. Supp. 2d at 1035 (in a D&E, physicians "deliver a leg or arm or more of the fetus intact into the vagina. . . . 'before' then performing a

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[8](...continued)
the state concedes to be constitutionally protected. *See Houston v. Hill*, 482 U.S. 451, 468-69 & n.18 (1987) (refusing to certify question of statutory construction where, "even if there were" a "reasonable way to read the plain language" of the law as the state urged, "such a limitation would not significantly limit its scope"). Finally, to the extent that the state insists on the relevance of the legislative history of the *federal* ban, *see* Pet'rs' Br. at 3-4, 43-44, that history indicates that, when originally added to the federal bill, the term "procedure" in the "for the purpose" clause referred to the abortion itself, and not to a "separate and distinct" sub-procedure within the abortion. The clause was meant to distinguish abortions from intended live deliveries that had gone awry. Introducing the 1997 federal amendment that added the phrase, "for the purpose of performing a procedure the physician knows will kill the fetus," H.R. 1122, 105th Cong. (1997), the Senate sponsor explained:

> [T]he AMA was concerned that . . . some zealous prosecutor could come out and accuse the doctor, who has not performed an abortion -- *does not intend to perform an abortion* -- but performed a normal delivery and, because of a complication, that somehow he or she could be covered under this act. We have tightened up the language with mens rea, to use the legal term. That directs the mental state -- *as to what the doctor was doing when he was delivering the baby for the purpose of a live birth and is not doing an abortion.*

143 Cong. Rec. S4671 (daily ed. May 19, 1997) (Sen. Santorum) (emphases added).

procedure or procedures which they know will kill the fetus" (citation omitted)).[9]

For all of these reasons, the Eighth Circuit correctly found that D&Es contain all the elements of conduct proscribed under the Act. Based on that finding, this Court should affirm the Eighth Circuit's holding that the Act "'plac[es] a substantial obstacle in the path of a woman seeking a pre-viability abortion' . . . and, in doing so, imposes an undue burden." *Carhart*, 192 F.3d at 1151 (citations omitted).

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[9] Were the Court to accept the state's insupportable assertion that the Act targets only abortions in which the physician performs "a separate and distinct 'procedure' *used to* kill" the fetus, Pet'rs' Br. at 17 (emphasis added), the Act would reach no abortions whatsoever, including D&X. For the record is clear that physicians performing D&X abortions collapse the skull only because it will not otherwise fit through the cervix; that they collapse the skull for the sole purpose of removing it; and that they proceed the same way regardless of whether the fetus has already died. *Carhart*, 192 F.3d at 1147-48 & n.9, *aff'g* 11 F. Supp. 2d at 1105-07, 1111. The purpose of either collapsing the fetal skull or dismembering the fetus is to complete the evacuation and not, specifically, to ensure fetal demise.

The state similarly fails to distinguish D&X as a targeted procedure when it asserts that D&X involves no "uncertainty as to when death will occur." Pet'rs' Br. at 18. The Act specifies a "procedure" that the physician knows will kill the fetus, and that does kill the fetus, before completion of the delivery; no more precise time of fetal demise is set forth. The physician knows that either dismemberment or collapsing the fetal skull will generally kill the fetus before the delivery is complete.

II. A BAN ON ANY ABORTION PROCEDURE WITHIN THE STANDARD OF CARE IMPERMISSIBLY HARMS WOMEN'S HEALTH, AND THE RISKS ARE ESPECIALLY GRAVE WHEN THE BAN INCLUDES NO HEALTH EXCEPTION AND ONLY AN INADEQUATE LIFE EXCEPTION.

Whenever the state criminalizes an abortion procedure that is within the standard of care, the ban removes from the physician's array of options a method that is the safest for some women in some circumstances. The ban compromises these women's health by forcing them from safer to riskier abortion procedures and depriving them of the right to decide from among medically approved alternatives which method best meets the compelling personal needs that surround their abortion decisions. Thus, even if the Act were somehow construed to prohibit only the D&X procedure, that prohibition would still unconstitutionally deny some women access to the method most protective of their health. The threatened harm is especially acute where, as here, the ban contains no exception to preserve a woman's health and only an inadequate exception to save her life. Because Nebraska's and the other states' "partial-birth abortion" bans, however construed, pose gratuitous risks to women's health, they are unconstitutional.

From *Roe v. Wade*, 410 U.S. 113 (1973), to *Planned Parenthood v. Casey*, 505 U.S. 833, this Court has held that the Constitution does not tolerate abortion restrictions that endanger women's health. Statutes that either prohibit or prescribe certain abortion methods have met with particular skepticism because of the health risks that flow from legislative attempts to micro-manage surgical technique. *See Danforth*, 428 U.S. at 75-79; *Colautti*, 439 U.S. at 397-401; *Thornburgh*, 476 U.S. at 768-69.

In *Danforth*, this Court identified several constitutional problems with a law banning saline induction. The statute prohibited what was then the most common method of post-first-trimester abortion. 428 U.S. at 77. The ban appeared also to encompass other existing abortion techniques as well as "methods that may be developed in the future and that may prove highly effective and completely safe." *Id.* at 78. And the law was anomalous in failing to prohibit "techniques that are many times more likely to result in maternal death." *Id.*

This reasoning goes beyond establishing a constitutional restraint on the prohibition of a common abortion procedure. The Court's stated concerns about laws that stymie medical progress and steer women to less safe alternatives apply even to a ban that takes narrow aim at a relatively new and still comparatively uncommon method, as the state argues is the case here. Thus, even if the Act prohibited only D&X (which it does not), and even if D&X could be consistently and reliably distinguished from D&E (which it cannot), the ban would still prevent the medical profession from fully assessing the safety advantages of D&X and perfecting the technique to maximize those advantages. Yet medical advancement in general and the ever-increasing safety of abortion practice in particular depend upon this process of developing, evaluating, and perfecting new techniques.[10] Similarly, even a ban that targeted only the D&X

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[10] In an attempt to establish -- in the face of amply supported, contrary findings by the district court, *Carhart*, 11 F. Supp. 2d at 1123-27 -- that the D&X procedure lacks medical benefits, the state emphasizes that D&X is a "relatively little used procedure," which has not yet been the subject of medical studies. Pet'rs' Br. at 32, 39. This, of course, will be true at some point for every new advance in surgical technique. The relative rarity of D&X and the paucity of studies establishing its safety are particularly unsurprising, given not only that it was only recently identified as a modification of D&E, but also that a sustained attack followed that identification. *See, e.g., Carhart*, 11 F. Supp. 2d at 1124-25 (finding that (continued...)

would "force[] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Danforth*, 428 U.S. at 79; *see* discussion *infra* pages 19-21.

If *Danforth* left any doubt about the unconstitutionality of a law that forces a woman to undergo what for her would be a riskier procedure, *Colautti* and *Thornburgh* resolve the question. In *Colautti*, this Court held void for vagueness a statute that directed a physician, performing an abortion when the fetus was viable or potentially viable, to use the technique most likely to preserve its life, unless a different technique was "'necessary in order to preserve the life or health of the mother.'" 439 U.S. at 397 (quoting statute). Interpreting the word "necessary" in this context to suggest that a procedure be "indispensable to the woman's life or health -- not merely desirable," *id.* at 400, the Court concluded,

> [I]t is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a "trade-off" between the woman's health and additional percentage points of fetal survival. . . . [W]here conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision . . . .

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[10](...continued)
"many accepted surgical techniques . . . are commonly developed without statistical studies" and that D&X is "well within accepted medical practice"); *Voinovich*, 911 F. Supp. at 1068-69 (rejecting argument that absence of studies requires conclusion that D&X has no benefits, and noting that "given the security concerns which must be considered by doctors who perform abortions, physicians who use the D&X procedure may be understandably reluctant to publicly acknowledge that they use this procedure, and may be even more reluctant to participate in a study and publish the results").

Id. at 400-01.

Faced with a similar statute several years later in *Thornburgh*, the Court declined to address the vagueness issue and invalidated the law instead on the ground that it violated a woman's right to end her pregnancy by the means safest for her. 476 U.S. at 768-69 & n.14. The statute at issue required the physician to employ the procedure most likely to ensure that a viable fetus would be "'aborted alive unless,' in the physician's good-faith judgment, that technique 'would present a significantly greater medical risk to the life or health of the pregnant woman.'" *Id.* at 768 (quoting statute). Because the statute "require[d] the mother to bear an increased medical risk in order to save her viable fetus," the Court condemned the provision for preventing the physician from treating "maternal health" as his or her "paramount consideration." *Id.* at 768-69 (internal quotations omitted).

In *Casey*, the Court reaffirmed that a pregnant woman's overriding interest in protecting her health lies at the core of her constitutionally protected right to reproductive choice. Thus, the *Casey* decision continues to prevent states from restricting abortions even after fetal viability -- when the state's interest in protecting potential life is at its zenith -- unless the law provides exceptions for abortions that are necessary to preserve a woman's life or *health*. 505 U.S. at 846, 879. The Court upheld the medical emergency exception of the statute under review only after adopting a construction that "assure[d] that compliance with [the state's] abortion regulations would not *in any way* pose a significant threat to the life or health of a woman." *Id.* at 880 (internal quotations omitted) (emphasis added). Similarly, the Court upheld the statute's waiting period only after concluding, on the record before it, that "we cannot say that the waiting period imposes a real health risk." *Id.* at

886.[11] Had the statute subjected women to real health risks, the plurality opined, "we would be required to invalidate the restrictive operation of the provision." *Id.* at 880. Thus, under *Casey*, an abortion regulation that exposes women to real health risks by definition poses a substantial obstacle and imposes an undue burden. *Id.*

Where, as here, the state lacks even a legitimate interest in restricting the procedures a physician may use to terminate a pregnancy, *see infra* Point III, *any* incremental risk to the woman's health is unjustified. Under *Colautti* and *Thornburgh*, the state may not compel a woman to undergo a riskier abortion procedure even to save the life of a viable fetus. *A fortiori*, then, the state may not in this case relegate a woman to riskier procedures for *previability* abortions, when the fetus cannot survive outside the woman's body regardless of the method used to terminate the pregnancy. The ban at issue here poses real risks to more women (because more women seek abortions before fetal viability than after), and the state interests asserted are far weaker.

Indeed, by insisting that the ban prohibits only one, discrete, rare abortion procedure and leaves adequate alternatives available, the state in effect disclaims any interest in preserving the life of the fetus. This Court has never suggested that the state has any cognizable interest in regulating the means by which a physician causes the death of the fetus in an abortion, aside from regulations designed to promote maternal health (which this ban certainly is not). Nor is there a scintilla of evidence, in this case or any other, that the method the state

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[11] *See also Webster v. Reproductive Health Servs.*, 492 U.S. 490, 525 (1989) (O'Connor, J., concurring) (interpreting viability-testing requirements to mandate "only those tests that are useful . . . [and] that it would not be imprudent or careless to perform in the particular medical situation before the physician" (internal quotations omitted)).

claims to target is more cruel to the fetus than its alternatives or that a previable fetus experiences pain. *See infra* Point III. Because the Act in no way serves the state's interest in protecting fetal life, or any other legitimate interest, *id.*, the health risks it imposes are entirely gratuitous. In the absence of a state interest in potential life, nothing distinguishes this ban from a regulation that arbitrarily prohibits radiation as opposed to chemotherapy for cancer patients, or open heart surgery as opposed to angioplasty for patients at risk of heart failure. Yet a decision from among such treatment options, with full knowledge of their risks and benefits, has long been the patient's to make. As this Court recognized in *Casey*, "*Roe* . . . [has] doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection." 505 U.S. at 857 (citing, *inter alia*, *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990)).

In this case, the unwarranted risks to the health of pregnant women are real indeed. A statute that criminalizes D&E, and potentially also induction and suction curettage, *see supra* Point I, inevitably consigns women to narrow and dangerous alternatives. Even if the ban prohibited only D&X, however, the record in this and other cases establishes that, in the hands of a trained and experienced provider, that procedure may be even safer than D&E for some women. The district court's findings, based on extensive testimony and documentary evidence, list in detail several medical advantages of D&X:

> Intact removal of the fetus lowers maternal complications by preventing sharp fragments, such as pieces of long bone or skull fragments, from passing through the cervical os without some kind of covering or protection. . . .
>
> [I]ntact removal of the fetus minimizes the risk of damage to maternal structures from repeated

> use of instrumentation in the uterine cavity. The more times [the physician] must enter the uterus with an instrument, the more the complication rate multiplies. . . .
>
> Performing the . . . D&X procedure also allows a more accurate assessment of whether the uterine cavity has been emptied. Fetal and placental debris remaining in the uterus -- as is possible with a D&E involving dismemberment -- can cause infection, greater bleeding, and [other] risk[s].

11 F. Supp. 2d at 1107. Courts throughout the country have made similar findings based on similar evidence.[12] A ban on D&X would therefore subject abortion patients to "appreciably greater risks to their health and lives than are necessary." *Id.* at 1127.

Because D&X reduces the risks of cervical laceration, uterine perforation, and infection, among others, it has both advantages in general and particular benefits for some women. Several courts have found, for example, that D&X may be indicated when a fetus has a greatly enlarged head resulting from hydrocephaly or when an intact fetus would facilitate genetic testing for the complete assessment of fetal anomalies and of the

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[12] *See, e.g.*, *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 314 (D&X may be best procedure to save life or preserve health of woman); *Miller*, 30 F. Supp. 2d at 1161 (D&X is used to "minimize uterine or cervical perforation caused by fetal parts or by medical instruments"); *Jegley*, No. LR-C-97-581, slip op. at 55-56 (D&X "may be necessary in some situations to preserve the health of the woman" because it poses less risk of laceration and hemorrhaging than D&E); *Butterworth*, 54 F. Supp. 2d at 1153 (D&X reduces risk of uterine or cervical perforation); *Evans*, 977 F. Supp. at 1296 (detailing unanimous testimony of six expert physicians that D&X reduces risks associated with D&E, including risk of uterine perforation, cervical lacerations, hemorrhaging, and infection); *Voinovich*, 911 F. Supp. at 1069-70 (same).

risk of their recurrence in future pregnancies.[13] Similarly, because D&X involves relatively little instrumentation within the uterus, it may be the best procedure for women whose uteruses are particularly fragile because of scarring from prior surgery. *Voinovich,* 911 F. Supp. at 1067. Then, too, some women decide to have a D&X because they want an intact fetus so that they can hold it, grieve its loss, and bury it. *See* J.A. at 67-68 (testimony of Dr. Carhart); *see also* Maureen Paul, M.D., M.P.H., *et al.*, *A Clinician's Guide to Medical and Surgical Abortion* 136 (1999). For reasons like these, the American College of Obstetricians & Gynecologists has concluded that, although D&X (like any single procedure) may virtually never be "the *only* option to save the life or preserve the health of the woman," it may nevertheless be "the *best or most appropriate* procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based on the woman's particular circumstances can make this decision." J.A. at 600-01 (ACOG Statement of Policy) (emphases added).

Finally, the Act prohibits medically accepted procedures without any exception to protect a woman's health and with only an inadequate exception to save her life. Thus, a banned procedure is unavailable to *all* women in virtually all circumstances, *even when* medically indicated. This deficiency alone is fatal to the Act. An adequate medical emergency exception is the *sine qua non* of the constitutionality of a law restricting abortion because "the essential holding of *Roe* forbids a State from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *Casey*, 505 U.S. at 879-80.

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[13] *See, e.g.*, *Butterworth*, 54 F. Supp. 2d at 1153; *Verniero*, 41 F. Supp. 2d at 485; *Jegley*, No. LR-C-97-581, slip op. at 55-56; *Evans*, 977 F. Supp. at 1296; *Voinovich*, 911 F. Supp. at 1067.

When pregnancy threatens a woman's life or health, physicians must be permitted not only to provide an abortion, but also to use the method that they determine, in their best medical judgment, to be the safest for the patient. *See, e.g.*, *Thornburgh*, 476 U.S. at 769; *Colautti*, 439 U.S. at 387 ("*Roe* stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, *and in determining how any abortion was to be carried out*." (emphasis added)). In medical emergencies, the need for discretion is particularly acute, as the physician must rapidly and effectively make the best use of his or her experience to deal with a highly particularized, rapidly changing situation with potentially devastating consequences. *See, e.g., Voinovich*, 130 F.3d at 205 (denying physicians discretion to exercise good faith judgment could impermissibly chill them from performing abortions even "when the woman's health or life is threatened"); *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 314 ("During an emergency, doctors must act rapidly and address ever-changing crises. The state may not risk a woman's life merely because the tool for saving her life would be a particular abortion technique.").

In the face of these constitutional requirements and medical realities, the Act is fatally inadequate. Because it lacks a health exception, the Act forces a high-risk patient to make an untenable decision between undergoing a more dangerous procedure or continuing her pregnancy notwithstanding unknown health risks. *See, e.g.*, *Verniero*, 41 F. Supp. 2d at 502. Because a physician cannot always clearly distinguish between a threat to a pregnant woman's health and a threat to her life, those health risks may reach grave proportions. *See, e.g.*, *id.* (striking ban that would "[f]orc[e] a physician to wait until a pregnancy threatens a woman's life before resorting to a 'partial-birth abortion'"). Courts across the country have therefore

invalidated so-called "partial-birth abortion" bans for lack of constitutionally mandated health exceptions.[14]

Even the Act's life exception is inadequate. It exempts a physician from liability only if a banned procedure "*is necessary to save the life* of the mother whose life is endangered by a physical disorder, physical illness, or physical injury." Neb. Rev. Stat. § 28-328(1) (emphasis added). Thus, for example, if a hysterectomy or hysterotomy would also save a woman's life, the ban requires the physician to use that method even though it presents far greater risks to the woman's health. *See, e.g.*, *Verniero*, 41 F. Supp. 2d at 500 ("[P]hysicians who wish to continue performing abortions without risking exposure . . . may still perform hysterectomies and hysterotomies. However, these procedures carry enhanced risks of morbidity and mortality and hysterectomies render the woman sterile."); *Evans*, 977 F. Supp. at 1317-18 (same). Moreover, by limiting the exception to life-threatening physical conditions -- as opposed to mental illnesses that often cannot be optimally treated during pregnancy and that may render the woman so dangerous to herself as to threaten her life -- the Act violates *Casey*'s command that abortion restrictions contain an exception to save a woman's life, whatever the source of the risk. *See* 505 U.S. at 879. Furthermore, the Act does not clearly allow physicians to rely on their own best medical judgment in determining that a banned procedure is necessary to save the patient. Yet physicians can and do regularly differ, both about the point at which a patient's condition becomes life-threatening and about the steps that may be necessary to keep her alive. *See, e.g.*, *Voinovich*, 130 F.3d at 205. A provision permitting

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[14] *See Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 314-15; *Causeway*, 43 F. Supp. 2d at 613-14; *Miller*, 30 F. Supp. 2d at 1167-68; *Verniero*, 41 F. Supp. 2d at 501-03; *Butterworth*, 54 F. Supp. 2d at 1156; *Jegley*, No. LR-C-97-581, slip op. at 51-61; *Woods*, 982 F. Supp. at 1378.

physicians to rely on their good-faith professional judgment in medical emergencies is constitutionally compelled to avoid the severe and irreparable harm that can result from a physician's hesitation in such circumstances. *See Colautti*, 439 U.S. at 395-96, 401 (statute requiring viability determination and prescribing certain abortion techniques is void for vagueness in part because it does not clearly allow physicians to rely on good-faith judgments); *Voinovich*, 130 F.3d at 204-05 (same, as to statute lacking good-faith provision in its medical emergency exceptions).

For all of these reasons, the Act, even if construed to ban only D&X, subjects women to increased health risks that are both real and wholly unjustified. *See infra* Point III. Because it deprives a woman of her overriding right to have an abortion by the method that best protects her health, the ban is unconstitutional.

III. THE ACT FAILS TO SERVE ANY LEGITIMATE STATE INTEREST.

The Act fails not only the heightened scrutiny that *Casey* and its antecedents mandate for judicial review of restrictions on the right to reproductive choice, but even the minimum rational basis test to which all legislation is subject. It is a fundamental principle of due process that the state must at least have a rational basis for regulating the conduct of individuals. *See Casey*, 505 U.S. at 848 (the "liberty" protected by the Due Process Clause "'includes a freedom from all substantial arbitrary impositions and purposeless restraints'" (quoting *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting))). This principle requires that the Act serve at least some legitimate state interest. Yet Nebraska's ban advances neither of the two interests that the Supreme Court identified in *Casey* -- "interests in the health of the woman and in protecting the potential life

within her," *id.* at 871 -- nor any other legitimate state interest. As Chief Judge Posner concluded in dissent from the Seventh Circuit's decision upholding the Illinois and Wisconsin "partial-birth abortion" bans, the laws "can fairly be described as irrational" and are therefore unconstitutional. *See Hope Clinic*, 195 F.3d at 880 (Posner, C.J., dissenting).

As an initial matter, the Act would not protect women's health; on the contrary, it would seriously threaten their health. *See supra* Point II; *see also Hope Clinic*, 195 F.3d at 878 (Posner, C.J., dissenting) ("The [Wisconsin and Illinois 'partial-birth abortion'] statutes do not seek to protect the lives or health of pregnant women, or of anybody else . . . ."); *Verniero*, 41 F. Supp. 2d at 504 ("The [New Jersey "partial-birth abortion"] Act does not protect the Legislature's legitimate interest in the health of the mother, but rather, poses a threat to the health of the woman." (citation omitted)). That the Act contains no exception to allow a physician to perform a banned procedure when the woman's health is at stake confirms the state's antagonism or, at a minimum, indifference to maternal health. As Chief Judge Posner explained,

> [The bans] are concerned with making a statement in an ongoing war for public opinion . . . . The statement is that fetal life is more valuable than women's health. I do not deny the right of legislatures to enact statutes that are mainly or for that matter entirely designed as a statement of the legislators' values . . . . But if a statute burdens constitutional rights and all that can be said on its behalf is that it is the vehicle that legislators have chosen for expressing their hostility to those rights, the burden is undue.

Hope Clinic, 195 F.3d at 880-81 (citation omitted).

Nor does the ban advance a state interest in preserving fetal life. If, as the state contends, the legislature meant to target only one procedure, Pet'rs' Br. at 22-23, then the government must have intended to steer doctors and patients to alternative methods of abortion. Such a purpose has nothing to do with saving "the lives of fetuses either directly or by seeking to persuade a woman to reconsider her decision to seek an abortion." *Hope Clinic*, 195 F.3d at 878 (Posner, C.J., dissenting); *see also Verniero*, 41 F. Supp. 2d at 504 (holding that New Jersey ban does not serve state interest in potential life because it simply "places the woman in the position of finding another way to obtain an abortion").

In effect conceding, as it must, that the Act serves neither of the state interests this Court has recognized, the state asserts other interests that this Court has never acknowledged as legitimate to support the regulation of abortion. The state posits that the Act serves "a compelling interest in erecting a barrier to infanticide." Pet'rs' Br. at 49. This argument rests on the proposition that the legal status of the fetus changes -- that the fetus approaches personhood -- once a "substantial portion" is delivered from the uterus into the vagina. Yet, as the evidence in this and other cases challenging similar bans shows, in the safest and most common abortion procedures, the physician routinely causes fetal demise only after what may be a "substantial portion" of the fetus has been delivered from the uterus into the vagina. *See supra* Point I. Thus, if the state's theory were correct, the state would be permitted to ban virtually all abortions by recharacterizing them as births in progress -- a result that *Roe* and *Casey* absolutely foreclose. *Casey*, 505 U.S. at 846, 878-79; *Roe*, 410 U.S. at 153, 164; *see* Pet'rs' Br. at 49 (referring to banned procedures as "induced birth process[es]").[15]

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[15] To the extent that the state's argument implies that a "partially born" fetus (continued...)

Moreover, although it is certainly true that Nebraska has a clear and important interest in protecting the life of viable fetuses, nothing in the Act limits the ban's reach to viable fetuses, as the state concedes. *See, e.g.*, Pet'rs' Br. at 48 (conceding that D&X is usually performed prior to viability). In any event, the state's legitimate interest in protecting viable fetuses is already fully served by Nebraska's statute banning post-viability abortion by any method, except when necessary to preserve the woman's life or health. Neb. Rev. Stat. § 28-329 (1995).

Finally, the state asserts interests in preventing cruelty to fetuses, disrespect for potential life, and an erosion of the integrity of the medical profession. Pet'rs' Br. at 48. None of these interests has any basis in the evidence. It is difficult to imagine that a D&X is more painful than a D&E involving dismemberment, *see Eubanks*, 28 F. Supp. 2d at 1042, or that collapsing the fetal skull is more cruel when the fetus is partially outside than when it is wholly inside the uterus, *see Hope Clinic*, 195 F.3d at 879 (Posner, C.J., dissenting). In any event, no evidence suggests that a previable fetus experiences any

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[15](...continued)
is a person entitled to Fourteenth Amendment protection, the implication conflicts with governing precedent. This Court has held that a fetus is not constitutionally protected at any time until it is born alive, *see Roe*, 410 U.S. at 156-62, which does not occur until its "complete expulsion or extraction from [the] mother," *Black's Law Dictionary* 184 (6th ed. 1990). For if the fetus were a constitutional person, *no* abortion (except perhaps a lifesaving one) would be permissible. But, as Justice Stevens has noted, "[N]o Member of the Court has ever questioned th[e] fundamental proposition" that a fetus is not a "person" within the meaning of the Fourteenth Amendment. *Casey*, 505 U.S. at 913 (Stevens, J., concurring). Even the dissenting Members of this Court in *Casey* did not argue that a fetus is a constitutional person. *See, e.g., id.* at 979 (Scalia, J., dissenting) ("The States may, if they wish, permit abortion on demand . . . .").

consciousness of pain. *See, e.g.*, *Voinovich*, 911 F. Supp. at 1074-75.

Instead, these asserted state interests appear to be reflections of repugnance. Repugnance, however, is so limitless a ground for the regulation of abortion as to swallow the established constitutional rights against which the state interests are to be weighed. *See, e.g.*, *Hope Clinic*, 195 F.3d at 879 (Posner, C.J., dissenting) ("No reason of . . . morality that would allow [a concededly constitutionally protected abortion] would forbid [a D&X]."). If the state has license today to enforce a ban on any abortion in which a substantial portion of the fetus is vaginally delivered before the fetus is killed, what prevents it tomorrow from enforcing a ban on any abortion in which the fetal body is in any way disarticulated? Reasonable people may endlessly debate which method is more offensive. Every method of abortion will be outrageous to some and at least unsettling to most. If that alone were sufficient to support bans on various procedures, a woman's right to obtain a safe and legal abortion would soon vanish. Yet *Casey* reaffirms that, in the continuing debate over the morality of abortion, "[t]he destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society" rather than on the dictates of the state. 505 U.S. at 852; *see also Thornburgh*, 476 U.S. at 759 ("'[I]t should go without saying that the vitality of these constitutional principles cannot be allowed to yield simply because of disagreement with them.'" (quoting *Brown v. Board of Educ.*, 349 U.S. 294 (1955))).

In sum, the Act is "not concerned with saving fetuses, with protecting fetuses from a particularly cruel death, with protecting the health of women, [or] with protecting viable fetuses." *Hope Clinic*, 195 F.3d at 880 (Posner, C.J., dissenting). Instead, the Act is essentially concerned with "dramatiz[ing] the ugliness of abortions and deter[ring] physicians from performing

them." *Id.* Because the Act has no purpose other than "to strike at the right itself," it is invalid. *Casey*, 505 U.S. at 874.

CONCLUSION

For these reasons, this Court should affirm the decision of the United States Court of Appeals for the Eighth Circuit invalidating Nebraska's ban on so-called "partial-birth abortion."

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